Links between mental health care professionals and general practices in England and Wales: the impact of GP fundholding

ROSLYN H CORNEY

SUMMARY

Background. *Fundholding general practitioners are able to determine the type of contracts they place with providers of mental health care, and are able to employ some categories of mental health care professionals directly. The impact of this on the care of the mental health of patients in non-fundholding practices is not yet fully known.*

Aim. *A survey was undertaken of 100 fundholding general practices and 100 similarly sized non-fundholding practices in order to investigate the changes in mental health provision made by general practitioners.*

Method. *A sample of 100 fundholding general practices in England and Wales was randomly chosen from the list supplied by the Association of Fundholders and matched to a similarly randomly chosen sample of non-fundholding practices. Postal questionnaires were sent to the senior partner and to the practice manager in each practice.*

Results. *The number of mental health care professionals who are either employed by or attached to general practices, or who visit the general practice on a regular basis appears to have increased substantially since 1991. This increase was particularly marked in fundholding practices. The results suggest that general practitioners with specific links to particular mental health care providers were more satisfied with the service provided by the mental health care team, and more likely to increase referrals to that service in the last 2 years, than general practitioners without such links. There was little evidence to suggest that increasing the number of mental health care professionals in primary care had brought about a major reduction in referrals to psychiatrists.*

Conclusion. *General practitioners, particularly fundholders, are increasing their links with mental health professionals, and community psychiatric nurses, psychiatrists, psychologists and counsellors are spending more time either based in general practice or visiting regularly. While the shift of resources to primary care, particularly to fundholders, may increase the treatment options available to patients with less severe illnesses, this may have the effect of reducing the services available for the long-term and severely mentally ill.*

Keywords: mental health professionals; GP links; interprofessional relationship; GP services; GP budget holder; randomized trials.

Introduction

THROUGHOUT the 1980s, the number of mental health care professionals who spent part of their time working with general practitioners in primary care settings has slowly increased.[1]

R H Corney, PhD, MSc, professor of psychology, University of Greenwich, London.
Submitted: 7 April 1995; accepted: 9 October 1995.

© *British Journal of General Practice,* 1996, **46**, 221-224.

The 1990 GP contract provided opportunities for increased collaboration between general practitioners and other health care professionals as it removed restriction on the range and number of staff for whom general practitioners could obtain reimbursement under the ancillary staff scheme. It also provided funding for health promotion clinics. However the money for this scheme was withdrawn after many psychologists and counsellors started working in practices and became accepted as part of the primary care team. A survey conducted in 1991, shortly after implementation of the 1990 contract, indicated that 48% of general practitioners had some link with a community psychiatric nurse, 21% with a social worker, 17% with a counsellor, 16% with a psychiatrist and 15% with a psychologist, although the actual amounts varied considerably with district and practice size.[1] Another, larger survey, conducted by Sibbald and colleagues, found that 31% of practices had links with a counsellor of some kind including community psychiatric nurses, counsellors and psychologists.[2]

It has been suggested that general practitioner fundholding has substantially increased the number of mental health professionals working within general practice.[3] A survey was undertaken to ascertain the status of 100 fundholding and 100 non-fundholding general practices with respect to their links with mental health care professionals.

Method

A sample of 100 first-wave fundholding general practices in England and Wales in April 1991 was randomly chosen from the list supplied by the Association of Fundholders. These practices were among the first group of approximately 300 to become fundholders. The names of the senior partner and the practice manager of each of the practices chosen were checked by telephone.

A control sample of 100 non-fundholding practices was also drawn by random selection using lists of comparable practices supplied by the 51 Family Health Service Authorities.

Two postal questionnaires were sent to the study practices in January 1994: one to the senior general practitioner; and one to the practice manager asking for more specific details. Non-respondents were followed up with reminders and a few (approximately 3% of the sample) were given a small payment for completing the questionnaire.

Replies to the questions were analysed using the chi-square test.

Results

Replies were received from 64% of the general practitioners in the fundholding practices and 51% in the non-fundholding practices. Less than half of the practice managers replied to the survey and their responses are not included in this paper.

The characteristics of the practices and the general practitioners who responded are shown in Table 1. No differences were noted between the fundholding and non-fundholding practices, or between responders and non-responders, in terms of location or

Table 1. Characteristics of respondents and their practices.

	Fundholding sample (n = 64) (% respondents)	Non-fundholding sample (n = 51) (% respondents)
Practice location		
Rural practice/small town	49	49
Large town	27	31
Conurbation	24	20
Number of partners		
Up to five	52	59
Six or more	48	41
Respondent male	90	86
Age of respondents (years)		
≤44	24	24
45–54	41	46
≥55	35	30
Respondents with post-registration training in psychiatry	12	13

practice size (according to the FHSA details on location, practice size and number of partners). The age, sex and training of the respondents in both samples were comparable (Table 1).

The general practitioners were asked to give details of the links their practice made with mental health care professionals, including clinical psychologists, psychiatrists, community psychiatric nurses, counsellors and psychotherapists. They were asked to indicated whether the mental health care professionals were employed by the practice (paid for by the practice, including the ancillary staff scheme), attached to the practice (spent one or more sessions per week in the practice) or liaising (a named professional visits the practice staff on a regular basis).

Fundholding practices had significantly more links with mental health care professionals than non-fundholding practices (χ^2 15.7, d.f. = 5, P<0.01). Only 9% of fundholding practices had no links with any mental health care professionals, 30% had a link with one mental health profession, 31% with two, and 30% with three or more mental health professions. Out of the non-fundholding practices, 31% had no links, 33% had links with one mental health care professional, 20% with two, and 16% with three or more.

The status of the different mental health care professionals linked with the study practices is shown in Table 2. In general, fundholding practices had more links with each type of mental health care professional than non-fundholding practices. However, the differences between fundholders and non-fundholding practices were only statistically significant for the links with counsellors (χ^2 6.5, d.f. = 1, P<0.01), most of whom were employed directly by the practice.

The general practitioners from fundholding practices were asked if they thought their fundholding was responsible for these changes: in 51% of the practices where changes in links with mental health care professionals were indicated, the general practitioner considered fundholding to be responsible.

Referral patterns

It is essential to ascertain whether changing the delivery of mental health services to the practice affects general practitioners' referral patterns. The general practitioners in this study were asked to indicate whether numbers of referrals to the various mental health care professionals had increased, decreased or stayed approximately the same over the 2 years leading up to the survey. In most cases, it must be assumed that the answers were based on subjective impression and that few respondents based their answers on actual referral figures.

Fundholding general practitioners appeared more likely to increase their rate of referral to community psychiatric nurses (χ^2 13.6, d.f. = 2, P<0.01), psychologists (χ^2 23.5, d.f. = 2, P<0.0001), counsellors (χ^2 20.1, d.f. = 1, P<0.0001) and psychotherapists (χ^2 13.5, d.f. = 2, P<0.001) when these professionals were linked in some way with the practice than when they were not linked to the practice. This was also generally true for the non-fundholding practices, although the differences were less marked than in the fundholding practices.

There was only a limited amount of evidence to support the view that increasing the number of mental health care professionals (excluding psychiatrists) attached to or employed by the practice markedly reduced referrals to psychiatrists. Out of the general practitioners from practices without any links to mental health care professionals (psychologists, community psychiatric nurses, counsellors and psychotherapists), 30% indicated that their rate of referral to psychiatrists had increased since 1991, while only 5% indicated a decrease. General practitioners from practices with links with three or more of the above mental health professions were much more likely to indicate a decrease in referrals to psychiatry. Thirty-seven per cent of this latter group indicated a decrease since 1991 and only 11% an increase in referrals to psychiatry. However, this finding was not statistically significant (χ^2 10.3, d.f. = 6, P<0.11).

Table 2. Practices reporting links with a mental health care professionals.

	Status of link with practice (%)			Overall percentage of respondents with a link
	Employed	Attached	Liaising	
Psychiatrist	14:8*	10:4*	6:8*	27:20*
Community psychiatric nurse	14:21	32:29	35:19	67:51
Psychologist	22:15	19:13	8:4	39:24
Counsellor	38:23	22:13	6:2	53:29
Psychotherapist	6:6	5:2	2:0	9:8

*Fundholders (n = 64): non-fundholders(n = 51).

Table 3. Satisfaction expressed by general practitioners regarding mental health care provision.

Mental health care professional	Fundholding practices satisfied No. (%)	Non-fundholding practices satisfied No. (%)
Psychiatrist	44 (70)	36 (74)
Community psychiatric nurse	43 (69)	39 (80)
Psychologist	30 (52)	18 (40)
Counsellor	37 (71)	19 (43)
Psychotherapist	20 (43)	10 (25)

Percentages are calculated after excluding non responses.

Satisfaction with services

General practitioners were asked whether they were satisfied with the services they received from mental health care professionals (Table 3). In general, those linked with the various mental health care professionals were much more likely to be satisfied than those with no links. In fundholding practices, more general practitioners indicated satisfaction with the service received from community psychiatric nurses (χ^2 10.5, d.f. = 1, $P<0.001$), counsellors (χ^2 5, d.f. = 1, $P<0.05$) and psychotherapists (χ^2 4.7, d.f. = 1, $P<0.05$) when links existed that when they did not. In non-fundholding practices, more general practitioners were satisfied with the psychology services when the psychologist was linked to the practice than when they were not (χ^2 13.4, d.f. = $P<0.001$).

The future

The general practitioners were asked whether they would like more links with mental health care professionals in the future. Responses are shown in Table 4. Although general practitioners without links were slightly more interested in increasing links with mental health care professionals than those in practices in whom links already existed, a substantial number of general practitioners without links were not.

Discussion

The response rate to this survey was low, particularly among general practitioners from non-fundholding practices, which could have produced a bias in the results. However, the fundholding practices and non-fundholding practices did not differ greatly in terms of location or practice size, nor did responders and non-responders (according to the FHSA details on location, practice size and number of partners). The age, sex and training of the general practitioner respondents in the two samples were also not significantly different.

The sample included only practices with a list size of 9000 or more, which is reflected by the lower proportion of practices included from conurbations. It is possible that the linkage figures reported are overestimates as general practitioners from practices that are less interested in mental health care issues may have been less inclined to respond. This survey also did not include smaller or single-handed practices, which might have fewer links with mental health care professionals than larger practices.

General practice has undergone major changes over the last 10 years and the results of this survey indicate the extent of this change within the mental health care sector. Ten years ago, few practices would have had links with any mental health care professional, now only 9% of first-wave fundholder practices and 31% of comparable non-fundholding practices have no links — and this study indicates that more links are being planned.

Table 4. Responding general practitioners who would like to increase links with mental health care professionals.

Mental health care professional	Links existing No. (%)	No links existing No. (%)	Overall No. (%)
Psychiatrist	5 (19)	33 (38)	38 (33)
Community psychiatric nurse	29 (42)	20 (44)	49 (43)
Psychologist	11 (30)	27 (35)	38 (33)
Counsellor	12 (25)	30 (46)	42 (37)
Psychotherapist	3 (30)	26 (25)	29 (25)

The advantages of mental health care professionals being part of the primary health care team have been reported as improved patient access to treatment, a closer involvement with the patient's family, increased opportunity for preventive work, more scope for an educational/consultative role and increased general practitioner satisfaction.[4] The present study also found increased general practitioner satisfaction when there were specific links, particularly in the fundholding practices.

Other commentators consider close links between general practitioners and mental health professionals to have a number of disadvantages, including the increased costs to the national health service of the extra staff involved. Marks describes how any new specialist service in the NHS, in addition to satisfying existing needs, creates new demand.[5] This was borne out by a study by McAllister and Phillip,[6] who asked general practitioners referring patients to psychologists how these patients would have been dealt with if they had not been referred. The general practitioners indicated that about 50% of these patients would have remained entirely under the general practitioner's care if the psychologist's service had not been available. General practitioners in this study with links to a particular mental health care professional were more likely to increase referrals to that professional. There was no conclusive evidence that developing links with non-psychiatrists had brought about a reduction in referrals to psychiatry (although this could happen in the long term). It does seem likely that high proportions of those referred to these mental health professionals would have been in the past cared for solely by general practitioners or other members of the primary care team.

It has been argued that the costs of the extra staff may be offset by reduced consultation rates, reduced drug consumption and improved outcome of the patients referred. At present, findings of research studies are equivocal and evidence on the long-term effectiveness of the various treatments within primary health care (including the cost-effectiveness) is lacking.[7,8] There are also issues of equity, patients from practices with specific links with mental health professionals have improved access to these services. As more mental health care professionals work in primary care, fewer will be available in other settings for patients referred from practices with no links. Thus, patients from practices who do not want to forge such links (and the results of this survey indicate that this is a substantial proportion of practices) may have problems in obtaining access to mental health care.

The demand from general practitioners poses many questions for providers of mental health care. General practice provides a very attractive working environment for mental health care professionals, with increased professional autonomy and a highly motivated clientele.[9] Concern has been expressed that, given the severe shortage of mental health care professionals, expansion into primary care will probably mean fewer trained staff available in other areas of great need such as treatment of long-term mental illness, psychogeriatrics or treatment of learning difficulties.[9]

Mental health care may become fragmented if mental health care professionals are working as part of the primary care team rather than as multidisciplinary mental health care teams in the community. The shift of resources to primary care, in particular to general practitioner fundholders, may also mean that services to the long-term mentally ill are reduced. In order to make the best use of the available resources, it is crucial to evaluate a number of different ways of providing mental health care in the community and to investigate the roles of the primary health care team itself.

References

1. Thomas R, Corney RH. A survey of schemes linking mental health professionals to general practice in six district health authorities. *Br J Gen Pract* 1993; **42:** 358-361.
2. Sibbald B, Addington-Hall J, Brenneman D, Freeling P. Counsellors in English and Welsh general practices:their nature and distribution. *BMJ* 1993; **306:** 29-33.
3. Green B. Developing a primary care and community psychology service. *Clin Psychol Forum* 1994; **March:** 32-35.
4. Corney RH, Jenkins R. *Counselling in general practice.* London: Routledge, 1993.
5. Marks IM. Cure and care of neurosis. *Psychol Med* 1979; **9:** 629-660.
6. McAllister TA, Phillip AE. The clinical psychologist in a health centre: one year's work. *BMJ* 1975; **iv:** 513-514.
7. Corney RH. Counselling in general practice — does it work? Discussion paper. *J Roy Soc Med* 1990; **83:** 253-257.
8. Gournay K, Brooking J. Community psychiatric nurses in primary health care. *Br J Psychiatry* 1994; **165:** 231-238.
9. Spector J. Clinical psychology and primary care: some ongoing dilemmas. *Bull Br Psychol Soc* 1984; **37:** 73-76.

Acknowledgements

This study was funded by the Department of Health. Many thanks are owed to Dr J Hammond who was involved in the selection of the non-fundholding sample, the postal survey and coding of the responses.

Address for correspondence

Professor R H Corney, Bronte Hall, University of Greenwich, Avery Hill Road, London SE9 2HB.

ROYAL COLLEGE OF GENERAL PRACTITIONERS SCOTTISH COUNCIL

ANNUAL SCIENTIFIC MEETING

to be held on Saturday morning

2 November 1996
at the
Jarvis Ellersly House Hotel
Ellersly Road
Edinburgh
EH12 6HZ

CALL FOR PAPERS

This is a call for papers for this year's Annual Scientific Meeting of Scottish Council RCGP. Submissions are invited for presentation and discussion. Those interested should send for further details from:

Dr Ross J Taylor
Chairman, Scottish Research Advisory Committee
Royal College of General Practitioners
Scottish Council
2 Hill Square
Edinburgh EH8 9DR
Tel: 0131 667 3115 Fax: 0131 667 1060

CLOSING DATE FOR PAPERS: 1 AUGUST 1996

Montpellier Health Care

NHS Hospital Locums Resident Medical Officers
- ACLS training provided to full time employees
- Wide variety of work Midlands & Southern UK
- Loyalty bonuses

GP Locums
- Short & long term posts
- Run by GP's
- Excellent rates
- Prompt payment

London 0171 431 3391
Birmingham 0121 705 7052
Midlands 01242 221685
Bristol/SW 01179 744999

FRES Member

Institute of Laryngology and Otology
University College London
Royal National Throat, Nose and Ear Hospital

MSc AUDIOLOGICAL MEDICINE

A multi-disciplinary taught course providing a comprehensive understanding of the scientific, technical and medical basis of Audiological Medicine is offered to Audiological Physicians, Paediatricians and Neurologists, commencing 23 September 1996. The course may be taken full-time over one calendar year or over two years on a part-time basis.

The unique facilities, clinical material and breadth of research experience of the staff at the Institute and Hospital provide a perfect learning environment.

Further details from: The Course Secretary, Institute of Laryngology and Otology, 330/332 Gray's Inn Road, London WC1X 8EE
Tel. 0171-915-1590 or 0171-915-1630
Fax: 0171-278-8041